MEDI-CAL UPDATE Part 2
Billing and Policy
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Allied Health • Durable Medical Equipment & Medical Supplies

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Contents

Federal Deficit Reduction Act of 2005 Requirements Implemented

Effective January 1, 2007, all new provider applicants and all providers subject to re-enrollment processing will be required to certify that they comply with Section 1902(a) of the Social Security Act.

On February 8, 2005, President Bush signed into law the Deficit Reduction Act (DRA), which requires specified changes to Medicaid (Medi-Cal in California) law. One of those changes is the requirement for employee education about false claims recovery. These changes go into effect on January 1, 2007.

This article contains information about both the state and federal law regarding this new requirement. This article also serves as the official notice of new federal requirements for Medi-Cal providers in California.

Federal Law

Section 6032 of the DRA requires any entities that receive or make annual payments under the State Plan (Medi-Cal in California) of at least $5 million, as a condition of receiving such payments, to have established written policies and procedures about the Federal and State False Claims Act for their employees, agents and contractors.

Specifically, Section 6032 amends the Social Security Act, Title 42, United States Code, Section 1396a(a), by inserting an additional relevant paragraph, (68). To summarize, this new paragraph mandates that any entity that receives or makes payments under the State Plan of at least $5 million annually, as a condition of receiving such payments, must comply with the following requirements:

1. Establish written policies for all employees of the entity, including management and any contractor(s) or agent(s) of the entity. These written policies shall provide detailed information about the following:
   - Federal False Claims Act, including administrative remedies for false claims and statements established under Title 31, USC, Chapter 38.
   - State laws pertaining to civil or criminal penalties for false claims and statements; whistleblower protections under such laws; and the role of these laws in preventing and detecting fraud, waste and abuse in Federal health care programs.
2. The written policies must include details about the entity's policies and procedures for detecting and preventing fraud, waste and abuse.
3. Any employee handbook for the entity must include specific discussion of the laws about false claims and statements; the rights of employees to be protected as whistleblowers; and the entity's policies and procedures for detecting and preventing fraud, waste and abuse.

Oxygen and Related Equipment Policy: December Update

Most of the following article ran in the November Medi-Cal Update. Some updates, in underlined or struckout text, have been added to reflect new policy or rate information.

Legislation was signed July 12, 2006, amending *Welfare and Institutions Code*, Section 14105.48, specifying that effective for dates of service on or after January 1, 2007, reimbursement for oxygen delivery systems and oxygen contents shall utilize national HCPCS codes.

Therefore, effective for dates of service on or after January 1, 2007, the following coverage and reimbursement policy changes will be implemented.

Billing Guidelines
A chart has been inserted in the *Durable Medical Equipment (DME): Bill for Oxygen and Respiratory Equipment* section to show HCPCS oxygen and equipment codes that are:

- Reimbursable for the same date of service
- Not reimbursable in the same month as an initial purchase or rental

TAR Requirement
All requests for oxygen delivery systems, oxygen contents and related equipment will require a *Treatment Authorization Request* (TAR), which must be sent to the Fresno Medi-Cal Field Office. Authorization for oxygen therapy will be granted for the lowest cost delivery system that best meets the recipient's medical needs. Providers may need to request corrections to currently authorized TARs or submit new TARs for dates of service on or after January 1, 2007.

Reimbursement
Reimbursement rates for oxygen therapy services will be the lesser of the amount billed or 80 percent of the lowest maximum allowance of the California Medicare reimbursement rate for the same or similar item or service. Rates will be adjusted for the following HCPCS codes: A4615, A4620, E0424, E0425, E0430, E0441, E0442, E1353 and E1355.

Procedure Codes
The following HCPCS Level II oxygen delivery systems and oxygen contents procedure codes will be new benefits covered by Medi-Cal: E0439, E0440, E0443, E0444 and E1392*****.

* This code was activated with the 2006 HCPCS annual update effective for dates of service on or after November 1, 2006.

The descriptors for the following currently covered HCPCS Level II oxygen delivery system and oxygen contents procedure codes will be revised from local descriptors to national descriptors. Policy will be revised accordingly: E0424, E0441 and E0442.

All other currently covered benefits will remain in effect.

'One Unit of Oxygen' Redefined
One unit of oxygen equals "one month's supply," regardless of how many pounds or cubic feet of oxygen are supplied. This change in the definition of "one unit of oxygen" affects codes E0441, E0442, E0443 and E0444.

Please see **Oxygen**, *page 3*

Oxygen *(continued)*

Modifiers

The following three new HCPCS Level II modifiers are to be used only with rental of stationary gaseous (E0424) or liquid (E0439) systems or with rental of a non-portable oxygen concentrator (E1390, E1391). These modifiers are not reimbursable with any other codes.

QE Prescribed amount of oxygen is less than one liter per minute (LPM). The reimbursement amount is reduced by 50 percent.

QF Prescribed amount of oxygen is greater than four liters per minute and portable oxygen is also prescribed. The reimbursement amount is increased by 50 percent.

QG Prescribed amount of oxygen is greater than four liters per minute and portable oxygen is not prescribed. The reimbursement amount is increased by 50 percent.

Note: The rental rates for E0424, E0439, E1390 and E1391 will vary when billed with modifier QE, QF, QG or RR depending on the prescribed oxygen flow. For oxygen flow rates equal to or greater than one and equal to or less than four liters per minute, modifier RR is to be used as a single modifier. For claims submitted with modifier QE, QF or QG, it is not necessary to include modifier RR.

Criteria

Medi-Cal covers oxygen therapy for recipients who meet the established medical criteria. The requirements for establishing the medical necessity for oxygen are listed below.

A. *Laboratory evidence* of hypoxemia in the chronic stable state or exercise induced hypoxemia **and a prescription** from the recipient's physician specifying all of the following information must be submitted with the request for prior authorization:

1. The diagnosis or medical condition requiring supplemental oxygen
2. The oxygen flow rate requested
3. An estimate of the frequency (hours per day) and duration of use (months)

A prescription for "Oxygen prn" or "Oxygen as needed" is unacceptable.

Initial requests for oxygen must include a recent arterial blood gas (ABG) report (obtained within 30 days of the request), unless the recipient is unable to tolerate the test in which case an oximetry study is satisfactory. However, documentation from a physician must be submitted explaining the rationale for submission of an oximetry study instead of an ABG.

Supplemental oxygen requests require that the recipient's arterial partial pressure of oxygen (Pa_{02}) must be 55 mm Hg or less, or the oxygen saturation (Sa_{02}) must be 88 percent or less with the test taken on room air in the chronic stable state and, if hospitalized, no more than two days prior to hospital discharge.

If the arterial Pa_{02} is 56 – 59 mm Hg or the Sa_{02} is 89 percent, a secondary diagnosis is necessary, such as but not limited to: congestive heart failure, cor pulmonale or erythrocytosis/erythrocythemia. Medi-Cal field office consultants who are reviewing the medical necessity for supplemental oxygen use will take into consideration that the laboratory specified values above may vary due to factors such as a recipient's age, or the altitude level at which the test was taken.

If the arterial Pa_{02} is equal to or greater than 60 mm Hg or the Sa_{02} is equal to or greater than 90 percent, the medical necessity for oxygen is unlikely to be established. However, individual cases submitted with detailed documentation substantiating medical necessity will be evaluated on a case-by-case basis.

For pediatric recipients an oximetry study with Sa_{02} submitted with the TAR is satisfactory. No ABG is required. Requests for supplemental oxygen for pediatric recipients with a Sa_{02} of 90 mm Hg or greater will be considered on a case-by-case basis. Requests for supplemental oxygen for children with medical conditions covered by California Children's Services (CCS) should be submitted to the appropriate CCS county office for approval.

Please see **Oxygen**, *page 4*

Oxygen *(continued)*

B. A stationary oxygen system will be authorized unless the recipient's need to pursue usual activities with a portable oxygen system is established with the submitted documentation.

C. If the recipient's clinical condition or need for supplemental oxygen changes, the attending physician must update the medical documentation and laboratory evidence accordingly, and the oxygen and related equipment provider must submit the new data with a new TAR.

D. If the supplemental oxygen system requested is not the lowest cost system that will meet the recipient's medical needs, Medi-Cal will modify the request. If oxygen is used for less than 24 hours per day, Medi-Cal may pro-rate the reimbursement to reflect less than 24 hours per day utilization of oxygen. If there is medical necessity that justifies a recipient's use of a higher cost supplemental oxygen system, it must be documented in detail by the physician prescribing the system. If a higher cost system is requested only for the recipient's and/or provider's convenience, the TAR may be authorized but reimbursement will be at the rate of the lowest cost item.

E. If a patient qualifies for additional payment for greater than four LPM and also meets the requirements for portable oxygen (E0431 or E0434), payment will be made for either the stationary system (at the higher allowance) or the portable system (at the standard fee schedule allowance for a portable system), but not both. In this situation, if both a stationary system and a portable system are billed for the same rental month, the portable oxygen system will be denied.

F. Monthly rental and reimbursement for purchased oxygen concentrators (E1390, E1391 and E1392) include all accessories, delivery and set-up. A portable gaseous system may be added if there is a documented need for mobility or exercise.

G. After one year of oxygen therapy, re-certification is required for continued use. The request must include a recent ABG report (obtained within 30 days of the request), unless the recipient is unable to tolerate the test, in which case an oximetry study is satisfactory. However, documentation from a physician must be submitted explaining the rationale for submission of an oximetry study instead of an ABG.

This information is reflected on manual replacement pages dura 4 (Part 2), dura bil oxy 1 thru 11 and 13 (Part 2), dura cd 6 thru 9 (Part 2), medi non hcp 3 (Part 2), modif app 5 (Part 2) and tar dis cod 3 thru 5 (Part 2).

Durable Medical Equipment Policy Updates

Effective for dates of service on or after January 1, 2007, the following Durable Medical Equipment (DME) policy updates will apply:

Power Wheelchair Battery Charger Reimbursement
HCPCS codes E2366 and E2367 (power wheelchair battery chargers) are separately reimbursable with the rental or purchase of their associated equipment. Claims for these codes must be billed with modifier RR or NU. Labor charges (HCPCS code E1340) are not separately reimbursable for use of these items.

Pediatric Wheelchair Seating Systems
Providers are reminded that obsolete HCPCS codes E1012 and E1013 were replaced by HCPCS codes E2291 – E2294 (pediatric wheelchair planar/contoured seats and backs) with the 2005 HCPCS Update. Policies for the obsolete codes apply to the replacement codes.

This information is reflected on manual replacement pages dura 10 (Part 2), dura cd 1 (Part 2) and dura ex 4 and 5 (Part 2).

Lymphedema Pumps/Compression Devices Expanded Medi-Cal Coverage

Effective for dates of service on or after January 1, 2007, Medi-Cal will expand coverage of lymphedema pumps and compression devices to also include upper and lower extremity conditions. Previous policy limited use of these items to only post-mastectomy lymphedema syndrome.

All lymphedema pumps and compression devices (HCPCS codes E0650, E0651, E0655, E0660, E0665 – E0669 and E0671 – E0673) require prior authorization. They must be prescribed by a licensed practitioner within the scope of his/her practice and are subject to appropriate physician oversight. The ideal situation would be for these patients to be under case management. An initial 60-day trial rental may be authorized and must establish clinical effectiveness.

Lymphedema pumps/compression devices are subject to the following criteria:

- The beneficiary has a confirmed diagnosis of primary or secondary lymphedema, and
- Lymphedema has been shown to be associated with functional impairment of the beneficiary.
- Conservative medical therapies, such as elevation of the affected limb, exercise, massage and/or use of an appropriate compression bandage system or compression garment, have been tried for at least 30 days and failed to reduce prolonged lymphedema, and
- The patient has demonstrated compliance with the past recommended medical treatment(s).

All lymphedema pump/pneumatic compressor codes may be purchased (billed with modifier NU) or rented (billed with modifier RR) and are subject to sales tax. Purchase or continued rental may be authorized when there is documented effectiveness of the pump (a decrease in edema is documented by pre- and post-treatment measurements and/or documentation of functional improvement).

One of the following ICD-9 diagnosis codes is required on the *Treatment Authorization Request* (TAR), but is not required on the claim: 457.0, 457.1 or 757.0.

Lymphedema pumps and pneumatic compression devices are not covered when the above medical guidelines are not met and for other indications such as venous insufficiency. Pumps or sequential pneumatic compression are contraindicated in the presence of active infection or deep vein thrombosis in the affected limb.

This information is reflected on manual replacement pages dura bil dme 1, 24 and 25 (Part 2) and dura cd 23 (Part 2).

Urological Supplies Addition

Effective for dates of service on or after January 1, 2007, the following medical supply product code has been added to the *Medical Supplies List* section.

Description	Billing Code	Bill Quantity in Total Number of
Tubes, Clamps and Connectors	9999C	Each

This new code will cover urological leg straps (latex or fabric), extension tubing (for external or Foley catheters), external catheter straps, catheter/tubing straps, quick drain valves, tube connectors/adapters and thumb clamps.

Items are limited to no more than six in a 27-day period, per recipient, without prior authorization.

This update is reflected on manual replacement page mc sup lst4 26 (Part 2).

2007 CPT-4/HCPCS Code Update Reminder

The 2007 updates to *Current Procedural Terminology – 4th Edition* (CPT-4) codes and *Healthcare Common Procedure Coding System* (HCPCS) Level II codes become effective for Medicare on January 1, 2007. The Medi-Cal program has not yet adopted the 2007 updates. Providers must not use the 2007 codes to bill for Medi-Cal services until notified to do so in a future *Medi-Cal Update*.

Medical Supply Invoice Requirements Change

Effective retroactively for dates of service on or after January 1, 2006, the ship-to address can be excluded from the medical supply invoice if the invoice contains the business Drug Enforcement Agency (DEA) number. Providers may resubmit a claim if it was denied or suspended due to a missing ship-to address and a DEA number was present on the invoice.

This information is reflected on manual replacement pages mc sup ex 6 and 8 (Part 2).

HCPCS Code E0966 Restored in DME Section

Manual wheelchair accessory HCPCS code E0966 (headrest extension, each) was inadvertently removed from the *Durable Medical Equipment (DME): Billing Codes and Reimbursement Rates* section. The restored information is as follows:

HCPCS Code	Description	Monthly Rental	Purchase
E0966	Headrest extension, each	$ 7.04	$ 71.37

This information is reflected on manual replacement page dura cd 10 (Part 2).

California Children's Services Program Updates

Updates to the California Children's Services (CCS) Service Code Groupings (SCGs) are as follows:

Code	SCGs Updated	Effective for Dates of Service on or after:
Z5956	04	July 1, 2004
Z0306	01, 02, 03 and 07	July 1, 2006
C9225	01, 02, 03 and 07	November 1, 2006
J3490	01, 02, 03 and 07	December 1, 2006
J3590	01, 02, 03 and 07	December 1, 2006

Reminder: SCG 02 includes all codes found in SCG 01, plus additional codes applicable only to SCG 02. SCG 03 contains all codes found in SCG 01 and 02, plus additional codes applicable only to SCG 03. SCG 07 contains all codes found in SCG 01, plus additional codes applicable only to SCG 07.

New Medical Therapy SCG Added

Effective retroactively for dates of service on or after November 1, 2006, a new SCG has been added. Medical Therapy (SCG 11) codes are used by physical and occupational therapists. The codes contained in this new SCG are not included in any other SCG and SCG 11 does not include codes from any other SCGs.

This information is reflected on manual replacement pages cal child ser 1, 3, 16 and 24 (Part 2).

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Remove and replace:	cal child ser 1 thru 4, 15/16
Remove:	cal child ser 23
Insert:	cal child ser 23/24
Remove and replace:	dura 3/4, 9/10
	dura bil dme 1/2, 23 thru 28
Remove:	dura bil oxy 1 thru 11
Insert:	dura bil oxy 11 thru 16
Remove and replace:	dura cd 1/2, 5 thru 12, 23/24
	dura ex 3 thru 6
	mc sup ex 5 thru 8
	mc sup lst4 25/26
	medi non hcp 3
	modif app 5/6
Remove:	tar dis cod 3 thru 7
Insert:	tar dis cod 3 thru 10

* Pages updated due to ongoing provider manual revisions.